UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

RAPTIVA(efalizumab)

Patient name:_____Medicaid or SS#_____

Physician Name:_____ Contact person:_____

Phone#:_____Ext and opt_____Fax#_____

Pharmacy_____Pharmacy Phone#:_____

All information to be legible, complete and correct or form will be returned

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FAX DOCUMENTATION FROM PROGRESS NOTES OR IN LETTER OF NECESSITY

CRITERIA:

- **Age requirement:** > 18 years old
- **DIAGNOSIS:** Severe plaque psoriasis
- **Must have a trial on the following medications:**
  1. Methotrexate
  2. Acitretin (soriatane), or Methoxsalen, rapid, Oxsoralen-ultra
  3. Cyclosporin
- Rule out other concomitant immunosuppressive agents.
- Minimum body surface area involvement must be > 10%

AUTHORIZATION:

1 year

RE-AUTHORIZATION:

Initial authorization is 12 weeks. Subsequent authorization 1 year with documentation of sustained improvement.

7/19/6